

# University of New Hampshire Health Services

## Massage Therapy Intake Form

Please complete this confidential form prior to your massage therapy appointment. Not all questions are pertinent to every client's situation.

**PERSONAL DATA**

Name \_\_\_\_\_ Date \_\_\_\_\_

Date of Birth \_\_\_\_\_ ID Number \_\_\_\_\_

**HEALTH HISTORY**

Is this your first professional massage?      Yes    No

What would you like from your massage today? \_\_\_\_\_

Any areas of your body to focus on? \_\_\_\_\_

Any areas of your body to avoid? \_\_\_\_\_

Were you referred by a health care provider? Yes    No

If referred, please indicate by who and specialty: \_\_\_\_\_

**Current Health:** Are you currently experiencing or have any of the following (please ✓) :

Tension or soreness in a specific area	Overuse injury pain	
TMJ syndrome and/or teeth grinding	Accident or other injury pain	
Numbness or tingling	Chronic pain	
Frequent headaches	Shooting or stabbing pain	
Cardiac or circulatory problems	Neck pain	
Muscle trigger points	Back pain	

If you ✓ any of the boxes above, please explain: \_\_\_\_\_

Please list any medications you are taking and reasons for use: \_\_\_\_\_

Please list any supplements, herbs and/or vitamins you are currently taking: \_\_\_\_\_

Please list any allergies or sensitivities you have: \_\_\_\_\_

Do you wear contacts?      Yes    No

**Pain Assessment (if applicable):** On a scale from 0-10, 10 being the worst, please rate your pain:

Current Pain	0	1	2	3	4	5	6	7	8	9	10
Worst Pain	0	1	2	3	4	5	6	7	8	9	10
Least Pain	0	1	2	3	4	5	6	7	8	9	10

Please describe where you feel the pain: \_\_\_\_\_

**Medical Conditions:** Are you currently affected by or have experienced in the last two years (please ✓):

Accidents	Anemia	Anxiety	
Arthritis	Asthma	Bladder problem(s)	
Blood clot	Bone fracture	Bowel problem (s)	
Cancer	Chronic fatigue	Contagious illness	
Depression	Diabetes	Epilepsy	
Fever	Fibromyalgia	Heart condition	
High blood pressure	Hospitalization	Injuries	
Joint strain/sprain	Multiple Sclerosis	Pregnancy	
Skin problems (sunburn, rash, acne)	Stroke	Surgery	
Other			

If you ✓ any of the medical conditions above, please explain: \_\_\_\_\_

\_\_\_\_\_

*I understand that massage services are offered to be a health aid and are in no way meant to take the place of a health provider's care when it is indicated. Information exchanged during massage sessions is educational in nature and intended to help me become more familiar with my own health status.*

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date

Reviewed by: \_\_\_\_\_

Signature of massage therapist

\_\_\_\_\_  
Date